

# Presbyterian Support Central - Woburn Home

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## Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

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| <b>Legal entity:</b>  | Presbyterian Support Central  |
| <b>Premises audited:</b>  | Woburn Home   |
| <b>Services audited:</b>  | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care |
| <b>Dates of audit:</b>  | Start date: 29 September 2021    End date: 30 September 2021  |
| <b>Proposed changes to current services (if any):</b>   | None  |
| <b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> | 87  |

# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

| Indicator   | Description   | Definition   |
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|   | Includes commendable elements above the required levels of performance  | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls  | Standards applicable to this service fully attained                                  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk         |

| Indicator | Description  | Definition  |
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|           | A number of shortfalls that require specific action to address                               | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|           | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk   |

## General overview of the audit

Woburn Home by Enliven is a part of the Presbyterian Support Central organisation (PSC). The service provides rest home, hospital, and dementia level of care for up to 99 residents, on the day of the audit there were 87 residents.

This certification audit was conducted against the relevant Health and Disability Services Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, relatives, management, staff, and a general practitioner.

Woburn Home has a 2020-2021 business plan and a mission, vision and values statement defined. The home has had several management team vacancies since May 2021 including the facility manager clinical nurse manager and two clinical coordinator roles.

Woburn home has been run by interim manager since July 2021. She has 24 years' experience in aged care and has completed eight Enliven education sessions for managers in 2020- 2021. Recruitment process have been completed for a new non-clinical manager who will commence employment on 28 October 2021.

The audit identified improvements required around implementation of quality and management system, human resource management system, hot water and fridge temperature monitoring, and implementation of reactive building maintenance.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |
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The service complies with the Code of Health and Disability Consumers' Rights. Staff ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Policies are implemented to support residents' rights, communication, and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Staff and residents interviewed understood the complaint's management process.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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There is an overall quality monitoring programme (QMP) that is part of the quality programme and includes internal benchmarking with the other PSC sites. Internal Audits were undertaken and required corrective actions were followed. There is an annual and monthly meeting calendar and agenda to ensure consistent communication. There are human resources policies including recruitment, selection, orientation, and staff training and development. The service has a documented orientation programme for all roles within the service. There is an organisational training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Standards applicable to this service fully attained. |
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Registered nurses are responsible for each stage of provision of care. Assessments, care plans, interventions and evaluations have been completed within the required timeframes. Residents and family interviewed confirmed that the resident's needs/supports were being met. There is allied health professional input into the resident's care. Planned activities are appropriate to the residents' assessed needs and abilities in the rest home, hospital, and dementia care unit. Activities are varied, interesting and meaningful for the residents as evidenced on resident/relative interviews. Medications are managed and administered in line with legislation and current regulations. Registered nurses and senior healthcare assistants responsible for medication administration have completed annual competencies. The general practitioner/nurse practitioner reviews medication charts at least three-monthly. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. Nutritious snacks are available 24 hours.

## Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
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The facility has a current building warrant of fitness. There is a reactive and planned maintenance programme documented. Chemicals are stored safely throughout the facility. All resident rooms are spacious with a mix of ensembles and communal toilet/shower facilities. There are communal dining, lounge and activity areas that are safely accessible for all residents. There is sufficient space to allow the movement of residents around the facility using mobility aids. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessed. There is a secure outdoor courtyard in the dementia unit. Cleaners and laundry staff are providing appropriate services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or other emergency. There is a first aid competent staff member on duty at all times.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |
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There is a restraint policy in place that states the organisation's philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. On the day of audit there was one resident using restraint and two residents using enablers. Consents, assessments, and evaluations had been completed as per policy. Restraint minimisation, enabler use, and challenging behaviour training is included in the training programme.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

Infection control management systems are in place to minimise the risk of infection to consumers, staff, and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the staff. Documentation evidenced that relevant infection control education is provided to staff as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated, and reported to relevant personnel in a timely manner.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| <b>Standards</b>  | 0                           | 47                  | 0  | 1                                    | 2  | 0                                      | 0  |
| <b>Criteria</b>   | 0                           | 95                  | 0  | 5                                    | 1  | 0                                      | 0  |

| Attainment Rating | Unattained Negligible Risk (UA Negligible) | Unattained Low Risk (UA Low) | Unattained Moderate Risk (UA Moderate) | Unattained High Risk (UA High) | Unattained Critical Risk (UA Critical) |
|-------------------|--|------------------------------|--|--------------------------------|--|
| <b>Standards</b>  | 0  | 0                            | 0                                      | 0                              | 0                                      |
| <b>Criteria</b>   | 0  | 0                            | 0                                      | 0                              | 0                                      |



# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

| Standard with desired outcome  | Attainment Rating | Audit Evidence   |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA                | <p>Presbyterian Support Woburn Home has developed policies, procedures, and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Interviews were undertaken with six healthcare assistants (HCAs) who work across each service and the am and pm shifts, the recreation team leader, five registered nurses (RNs), a cleaner, two laundry assistants and the kitchen team leader. All confirmed their understanding of the Code. Interviews with seven residents (two hospital and five rest home) and five family members (one hospital, two dementia and two rest home) confirmed that the service functions in a way that complies with the Code of Rights. Observation during the audit confirmed this in practice. Staff receive training about resident rights at orientation and as part of the in-service training programme. Training on the Code is included as part of the orientation process for all staff employed.</p> |
| <p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information</p>  | FA                | <p>Residents and their families are provided with all relevant information on admission and staff hold discussions regarding informed consent, choice, and options regarding clinical and non-clinical services. Signed general consents were viewed in the nine files reviewed (three rest home, four hospital including one respite resident under ACC funding, and two dementia care residents). There were specific consents for vaccines.</p> <p>Clinical staff (interviewed) were knowledgeable of the informed consent process. Nine resident files</p>   |

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| <p>they need to make informed choices and give informed consent.</p>   |           | <p>reviewed had appropriately signed resuscitation forms for the competent resident. Where the resident was deemed to be incompetent the GP/NP had made a medical decision around resuscitation status. Enduring power of attorney has been activated for residents deemed to be incompetent. Where end-of-life wishes are known, these are included in the care plan. Advance care planning is being implemented. Discussion with families identified that the service actively involves them in decisions that affect their relative's lives.</p>   |
| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>       | <p>FA</p> | <p>Information about accessing advocacy services information is available in the entrance foyer. An information pack provided to residents at the time of entry to the service also provides residents and family/whānau with advocacy information. Interviews with HCAs, residents and family/ whānau members informed they were aware of advocacy and how to access an advocate.</p>  |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | <p>FA</p> | <p>On the day of audit, they were visitor's restrictions due to the current Covid-19 alert level, however family interviews confirmed that visits were available by appointment, and they felt comfortable about the way it was managed. Family interviews confirmed that they were kept well informed.</p> <p>Maintaining links with the community is encouraged. Pre Covid-19 activities programmes include opportunities to attend events outside of the facility. The facility supports the philosophy of The Eden Alternative, which is being implemented. There are number of volunteers who support residents with variety of religious, cultural, intellectual, and musical activities.</p>   |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>                                 | <p>FA</p> | <p>The complaints/compliments policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed were fully informed and knew how to do so. The interim manager has an open-door policy if family/resident/staff wish to discuss any issues or concerns. Complaints forms are located throughout the facility and are easily accessible.</p> <p>The complaints register is maintained by the interim manager. There were five complaints in the register for 2021. Three of these complaints were registered in May 2021 when the facility did not have a manager. With the appointment of an interim manager, these complaints were followed up. Issues raised were resolved and these were documented in the register. Interviews with the interim manager and clinical coordinator confirmed that complaints were followed up but the documentation at that time was not completed. In light of this information, auditors considered that the register is now up to date.</p> |

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|  |    | <p>There is one complaint registered through coronial services since 2020 and this remains open. A number of correspondences were maintained in the complaint register and Presbyterian South Central has undertaken full review of the issue and planning organisation wide improvements related to this case.</p> <p>All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. Management team interviews confirmed that residents were encouraged to talk with the RNs, clinical coordinators, or HCAs if they have any concerns.</p>   |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>  | FA | <p>Residents and family members interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through the admission information provided and discussion with staff. The Code is displayed in common areas, together with information on advocacy services, how to make a complaint and feedback forms. Code of Rights posters were on the walls in the facility.</p>  |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | FA | <p>There are policies in place to guide practice in respect of independence, privacy, dignity, and respect. The initial and ongoing assessment includes collecting details of people's beliefs and values. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Residents and families interviewed confirmed that staff understood the need to maintain privacy and residents were encouraged to be independent.</p> <p>Residents interviewed stated that they maintain their independence by community activities and going on regular outings. Care plans included documentation related to the resident's abilities, and strategies to maximise independence. Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified, documented, and incorporated into their care plan.</p> <p>Staff interviews confirmed that staff sought resident's consent for all day-to-day support and decision making, using ways appropriate to the resident's individual communication needs.</p> <p>Staff were knowledgeable about the various types of abuse and stated that residents were safeguarded against neglect and abuse. Management team members interviewed stated that they promote staff awareness about elder abuse and neglect through discussions, staff supervision and through meetings. Staff knew contact details and the role of National Advocacy Services and knew they could report concerns to management.</p> |

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| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | <p>FA</p> | <p>Enliven has adopted the Oranga Kaumatua Wellness Map after extensive consultation with the Enliven Cultural Advisory Group. During the development of the Oranga Kaumatua (OK) Wellness Map, the Cultural Advisory Group was based in Whanganui. The members of the group included staff, residents, local kaumātua and a whānau member who was also cultural advisor to the DHB and to the regional council. They were from a range of Iwi including two of the Whanganui Iwi, Nāati Kahungungu and Ngāti Porou. The OK Wellness Map was tested with Māori residents and whānau from three PSC facilities.; this is now implemented at Woburn Home.</p> <p>There were two residents who identified as Māori. Review of these files showed that care plans included cultures and preferences relevant to Māori. Extensive consultation with whānau was evident and staff interviewed were aware of the importance of whānau in the delivery of care for Māori residents.</p>   |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>           | <p>FA</p> | <p>Spiritual and pastoral care is an integral part of service provision. There are a mix of ordained Ministers and lay people who conduct services relevant to denominational framework. Facility runs and assists the faith based spiritual care of residents. The role includes services, giving communion, hymn singing and short sermons. There is a roster of people from various denominations of church services on Sunday afternoons. Participating churches are St James Anglican, St Peter &amp; Paul Roman Catholic, Hutt City Baptist Church and St Mark's Uniting Church.</p> <p>Family interviews confirmed that staff were proactive and helped residents maintain relationships with those that mattered to them. On the day of audit, due to Covid-19 alert level restrictions, the facility was accepting family visits by appointment.</p> <p>People's bedrooms were decorated to their taste and personalised with things that were meaningful for them. Relatives confirmed staff kept in regular contact with them and involved them in day-to-day decision making for people who lacked capacity. Care plans were reviewed six-monthly, including by telephone for relatives who don't live locally.</p> |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>   | <p>FA</p> | <p>Discrimination, coercion, exploitation and harassment policies and procedures are in place. A code of conduct and position descriptions outline staff responsibilities in terms of providing a discrimination-free environment.</p> <p>Staff interviews confirmed that staff understood and were confident about using the whistleblowing procedure and they felt that if a staff member raise a concern in good faith, it would have taken seriously, and investigated. The management team provides staff supervision to ensure safe care.</p> <p>Residents and family members interviewed stated that residents were free from any type of discrimination,</p>  |

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|  |    | harassment or exploitation and felt safe.  |
| Standard 1.1.8: Good Practice<br>Consumers receive services of an appropriate standard.  | FA | <p>There are comprehensive policies and procedures are in place to provide assurance that staff are meeting accepting good practice and adhering to relevant standards. As an organisation, Enliven has a policy review group with terms of reference and follow monthly policy review schedules. New policies are developed and generated from a central hub, they are introduced to staff at Woburn under the managers direction and staff are kept up to date with changes.</p> <p>There were number of environmental improvements since the last audit. There has been a major upgrade in the hospital courtyard with the creation of new gardens, replacement of the old pavers with exposed concrete, the addition of a small deck, shade cloth and several large plants in pots. The hospital wing has seen a major alteration with room and ensuite refurbishments. There were also number of improvements made in the dementia unit, these include a new kitchen, upgrade of the lounge, a self-service meal area and new carpeting.</p> <p>Improvements around clinical care includes the appointment of RN champions for wound care, palliative care, and infection control. PSC has appointed a nurse practitioner (NP) for their facilities who works alongside the facility general practitioner (GP). The GP/NP model of care was implemented from 1 April 2021 to improve services offered to residents. The clinical coordinator reported that the availability of the NP has improved the timeliness of access to medical care and clinical decision making.</p> |
| Standard 1.1.9: Communication<br>Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | <p>Residents and family members stated they were kept well informed of any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. Incident forms have a section to indicate if the family have been informed (or not) of an accident/incident. Ten incident forms reviewed for 1 July to 20 August 2021 identified family were notified following a resident incident. Relatives interviewed confirmed they are notified of any changes in their family member's health status. Interviews with HCAs confirmed that family are kept informed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to staff being able to provide interpretation as and when needed, and the utilisation of family members.</p>  |
| Standard 1.2.1: Governance<br>The governing body of the  | FA | Woburn Home by Enliven is a part of the Presbyterian Support Central organisation (PSC). The service provides rest home, hospital, and dementia level of care for up to 99 residents, on the day of the audit  |

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| <p>organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>   |               | <p>there were 87 residents: 33 rest home, 32 hospital and 22 dementia. Four beds are utilised as dual purpose. One hospital level resident was on respite care funded by ACC. All other residents were under the aged related residential care contract (ARRC).</p> <p>Woburn Home has a 2020-2021 business plan and a mission, vision and values statement defined. The business plan outlines a number of goals for the year, each of which has defined objectives against quality, Eden philosophy, and health and safety. Progress towards goals (and objectives) is reported monthly to the senior team meeting through a manager's report.</p> <p>Woburn Home had major management team vacancies since May 2021 including the facility manager, clinical nurse manager and two clinical coordinator roles. During this time, the dementia clinical coordinator has undertaken the managerial position until appointment of an interim manager, supported by the PSC office and an aged care nurse consultant.</p> <p>Woburn Home has been managed by an interim manager since July 2021. She has 24 years' experience in aged care and has completed eight Enliven education sessions for managers in 2020- 2021. She provides consultancy services for the Presbyterian Support Central, Enliven services. Recruitment processes have been completed for a new non-clinical manager who will commence employment on 28 October 2021, the interim manager will be supporting the new manager in his role through his orientation period and thereafter as required.</p> <p>There is a clinical nurse manager who started in the role in August 2021 and has 9 years' experience in aged care; she is supported by two clinical coordinators, one who was recently employed to a vacant position. Currently Woburn Home is advertising for another clinical coordinator.</p> |
| <p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p> | <p>FA</p>     | <p>The clinical nurse manager undertakes the role in the temporary absence of the home manager, supported by the Business Operations Manager and Clinical Director from Central Office.</p>  |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an</p>   | <p>PA Low</p> | <p>Policies and procedures are in place to provide assurance that staff are meeting accepting good practice and adhering to relevant standards. As an organisation, PSC Enliven has a policy review group with terms of reference, and they follow monthly policy review schedules. New policies are developed and generated</p>   |

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| <p>established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>   |           | <p>from the central hub and are introduced to staff at Woburn under the managers' direction to ensure that staff are kept up to date with changes.</p> <p>PSC has an overall quality monitoring programme (QMP) that is part of the quality programme and includes internal benchmarking with the other PSC sites. The senior team meeting acts as the Quality Committee. Key information is communicated to staff through various avenues. There is an annual and monthly meeting calendar. Full staff meetings are scheduled monthly, and minutes are made available to staff in the staffroom along with detailed minutes of senior staff and clinical meetings. H&amp;S meetings are scheduled four times per year; however, meetings were not conducted as planned.</p> <p>Enliven introduced facility health checks in 2017. Once a year, each home is peer reviewed by senior staff from other homes. This has resulted in sharing of quality improvement ideas between homes. It has also enabled Enliven to make improvements at all homes, based on the learnings from the health checks. Woburn had their last health check on 19 May 2021 and corrective actions on this review is work in progress.</p> <p>Staff payroll system provides an electronic messaging system that is used for "all staff" brief messaging. Staff must read the message before being able to "sign in" for their work shift. Clinical and care related information is shared through an electronic resident management system and at handovers or service specific meetings.</p> <p>The interim manager understands contractual agreements and requirements. The business operations manager provides oversight and support to the facility. An internal audit programme is implemented and feedback on monthly accident and incidents are provided to all staff. The service has linked the complaints process with its quality management system, including the benchmarking programme, and feeds outcomes from this back through meetings.</p> <p>A resident and relative satisfaction survey was last completed in 2020. Sixteen residents and 20 relatives were surveyed. These results were less favourably compared with the previous year however they were higher than Enliven average results in most categories across other facilities. Overall satisfaction with care and services at both residents and relative survey results were high.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where</p> | <p>FA</p> |   |

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| <p>appropriate their family/whānau of choice in an open manner.</p>  |                        |  |
| <p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | <p>PA<br/>Moderate</p> | <p>There is a human resources policy that includes recruitment, selection, orientation, and staff training and development. The recruitment and staff selection process requires that relevant checks are completed. A copy of qualifications and annual practising certificates are kept for RNs, general practitioners (GP) and other registered health professionals. Twelve staff files were reviewed including the clinical nurse manager, three RNs, four HCAs, two recreation coordinators, one laundry, and one cleaning staff member. The staff files reviewed had a job specific job description, interview notes, reference checks, police vetting, professional credentialing, and employment contracts.</p> <p>The service has a comprehensive orientation programme in place, but not all staff had completed orientation records. Staff performance appraisals are scheduled annually, but not all staff had completed annual performance appraisals in last two years.</p> <p>A training programme includes eight hours of annual education covering all mandatory topics over a three-year period; however, this is also not fully implemented. Three staff who works in the dementia unit do not have required dementia specific qualifications.</p> <p>These issues were also identified by the internal audit programme and a corrective action plan has been put in place by the interim manager.</p>   |
| <p><b>Standard 1.2.8: Service Provider Availability</b></p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>       | <p>FA</p>              | <p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. A number of RN shifts are covered by a nursing bureau. The management team reported that high turnover of staff to local DHB including RNs and HCAs along with the closed New Zealand borders are having a huge impact on staff recruitment and retention.</p> <p>The interim manager, clinical nurse manager, and clinical coordinators (two) all work full-time. Currently Woburn home is advertising for a clinical coordinator position and RNs. There is a 24-hour RN cover. Agency staff are used to provide cover for sickness if necessary. Interviews with HCAs, residents and family members identified that staffing is adequate to meet the needs of residents.</p> <p>In the hospital unit, there are 32 residents (capacity is 35). There is one-clinical coordinator who is supported by one RN on duty on the morning, afternoon, and night shifts. The RNs are supported by adequate numbers of HCAs. There are seven HCAs (five long and two short shifts) on duty on the morning shift, six HCAs (three long and three short shifts) on the afternoon shift and two HCAs on the night shift.</p> <p>In rest home unit, there are 33 rest home residents (capacity is 39). One RN on duty on the morning shift.</p> |



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|   |    | <p>There are four HCAs (three long and one short shifts) on duty on the morning shift, four HCAs (two long and two short shifts) on the afternoon shift and one HCA on the night shift.</p> <p>In the dementia unit, there are 22 residents (capacity is 25). There is one clinical coordinator on duty on the morning shift along with four HCAs (two long and two short shifts), and three HCAs (two long and one short shift) on the afternoon shift with two HCAs on night shift.</p>  |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>            | FA | <p>All necessary demographic, personal, clinical, and health information was fully completed and maintained in the electronic information management system. Day to day residents' cares were completed in this system by all disciplines including the nursing team, GP/NP, activities, and physiotherapist. Electronic records reviewed were current and accurate. This included interRAI assessment information entered into the Momentum electronic database and the electronic medication management system. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>No personal or private resident information was on public display during the audit. Staff access the electronic residents' information through use of individual passwords.</p> <p>Archived records have been electronically maintained since 2019.</p> |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | FA | <p>All residents are assessed prior to entry for rest home, hospital, or dementia level of care. The acting facility manager and clinical nurse manager are responsible for the screening of residents to ensure entry has been approved. An information booklet is given to all residents/family/whānau on enquiry or admission. Nine signed admission agreements were sighted. The admission agreement reviewed aligns with a) – k) of the ARC contract. Exclusions from the service are included in the admission agreement.</p>  |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>                            | FA | <p>The service has transfer/discharge/exit policy and procedures in place. All transfer and discharge summaries are kept on the resident file. Relatives are informed and involved in discussions regarding transfers to hospital or other providers.</p>  |

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| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>        | <p>FA</p> | <p>The medication management policies and procedures comply with medication legislation and guidelines. Registered nurses/senior HCAs who administer medications have completed medication competences and education on an annual basis. The service uses robotic rolls which are checked on delivery by a RN and date of checking entered into the electronic system. Medications are stored safely in the three units (rest home, hospital, and dementia unit). There are weekly checks of the hospital stock and emergency supplies for expiry dates. Medication fridges and room temperatures are monitored weekly. All eye drops in the medication trolleys had been dated on opening. There were no standing orders. There were no residents self-medicating. Eighteen medication charts (eight hospital, six rest home and four dementia care) were reviewed on the electronic medication system. All prescribing of regular and 'as required' medications met legislative requirements. The GP/NP review medication charts at least three-monthly.</p>   |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | <p>FA</p> | <p>All meals are prepared and cooked on-site in the main kitchen. The kitchen team leader is a qualified cook. The cook is supported by a team of cooks, cook assistants and dishwashers. Meals are transported in bain-maires and/or hot boxes to the rest home- adjacent to the kitchen where residents are encouraged to choose from the buffet what they wish to eat, hospital and dementia unit. There is a five-weekly rotating summer/winter menu in place that has been reviewed by a dietitian in August 2021. The main meal is at midday. Texture modified diets are accommodated including diabetic desserts. Resident dislikes are known, and alternative foods provided.</p> <p>The cook receives resident dietary profiles and is notified of any changes. Lip plates and specialised cutlery are available as needed. There are nutritious snacks available 24 hours in the dementia unit. The cooks and kitchenhands have completed food safety and hygiene training. The food control plan has been verified and expires 5 August 2022. End-cooked, bain-maire temperatures, main kitchen fridge and freezer temperatures are monitored and recorded daily. Cleaning schedules are maintained. Chemicals are stored safely. The chemical supplier conducts a chemical effectiveness check on the dishwasher monthly. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed confirmed satisfaction with the meals provided.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their</p>                                 | <p>FA</p> | <p>The service records the reason (no bed availability or unable to meet the acuity/level of care) for declining service entry if this occurs. Potential residents are then referred back to the referring agency.</p>   |

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| family/whānau is managed by the organisation, where appropriate.  |    |  |
| Standard 1.3.4: Assessment<br>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.         | FA | The residents' needs, support requirements and preferences have been collected and recorded within required timeframes. Information is also gathered from medical notes, discharge summaries, allied health involvement and from discussion with the resident/relatives on admission. The RNs complete applicable assessment tools on admission such as falls risk, pressure risk, dietary needs, continence, pain, mobility, behavioural, cognitive and depression. The outcomes of these assessments were reflected in the initial care plan. The first interRAI assessment had been completed within 21 days and the outcomes reflected in the long-term care plan. InterRAI assessments are completed at least six monthly or when there is a change to health status. Behavioural assessments had been completed in the two dementia care files reviewed. A tree of life and recreational assessment is completed soon after a resident's admission.  |
| Standard 1.3.5: Planning<br>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | <p>Nine long-term care plans reviewed were resident focused and evidenced resident/relative input into the care plan. An initial plan of care was developed on admission for the five resident files reviewed for this, the four remaining files were for residents who had been at the facility for over five years. The RN progress notes document communication with the family regarding the development and review of care plans. Long-term care plans for residents in the dementia unit include a behaviour management plan that describes the behaviours and interventions/de-escalation techniques including activities. The long-term care plans are updated as changes occur to health and are routinely reviewed three-monthly with a full evaluation six monthly. Care plans along with information in the electronic medication system reflected current supports required.</p> <p>The care plans demonstrate allied health involvement in resident care. Clinical records are electronic, and each resident file sampled had a recently introduced Oranga Kaumatua (Wellness Map) covering what was important to the resident. Short-term and/or specific care plans are available for use to document any changes in health needs with interventions, management, and evaluations. Short-term care plans/or specific care plans were sighted for infections, diabetic management, behaviour management, weight loss, bruising, oedema, falls and wounds. Short-term care plans reviewed had been evaluated at regular intervals and either resolved or if ongoing, added to the long-term care plan.</p> |
| Standard 1.3.6: Service Delivery/Interventions<br>Consumers receive adequate  | FA | When a resident's condition alters, a RN initiates a review and if required, GP or nurse practitioner consultation. The family members confirmed on interview they are notified of any changes to their relative's health including (but not limited to): accidents/incidents, infections, health professional visits, changes in  |

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| <p>and appropriate services in order to meet their assessed needs and desired outcomes.</p>  |           | <p>medications and challenging behaviours. Discussions with family members are documented.</p> <p>Adequate dressing supplies were sighted. Wound management policies and procedures are in place. There were seven wounds and one stage 1 pressure injury in the hospital, four wounds in the rest home (two chronic venous ulcers on one resident to which there had been extensive involvement by the DHB clinic and the wound nurse specialist. Fortnightly updates, including photos were forwarded to the nurse specialist and she was coming the day after audit for training on compression bandaging). There were no wounds in the dementia unit. Wound assessments, treatment and evaluations were in place for residents with current wounds. Chronic wounds are linked to the long-term care plans.</p> <p>The CNM has recently established portfolios for RNs including one for wound care for one RN to gain additional expertise and have oversight of all residents with wounds.</p> <p>Continence products are available and resident files include urinary continence assessment, bowel management and continence products identified for use.</p> <p>Monitoring forms (on the electronic care system) used include (but are not limited to), blood pressure monitoring, behaviour charts, restraint monitoring, blood sugar levels, food and fluid, neurological observations, re-position charts, pain monitoring and monthly weights.</p>   |
| <p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>FA</p> | <p>The recreational team leader has been in the role since July 2018 and is a qualified occupational therapist. She oversees the activity team of recreation officers for each area. Two recreation officers cover the three areas between them on Saturdays and one on Sundays. There are activity programmes for each of the units (rest home, hospital, and dementia care) with many some activities being integrated for all residents. Some facility residents also join in activities in the separate day support programme which is run onsite. There are plentiful resources. The Eden philosophy is implemented, and residents' skills and abilities are celebrated and valued within the programme. Volunteers (when not in covid lockdown) are involved in the activities. The programmes provide word games, floor games, exercises, newspaper reading, walking groups, poetry corner, baking, reminiscing, flower arranging, sing-a-longs, hand therapy and one-on-one activities, happy hours, weekly reflection group, arts and crafts, faith, and fellowship groups.</p> <p>The PSC chaplain visits regularly and also undertakes bible reading. There is a chapel for church services. There are several lounges where activities occur and a large lounge for integrated activities such as entertainment, bowls, visits from school groups, celebrations, and themed events. The residents and staff are involved in their 2021 Woburn Home Wearable Arts, showcasing costumes that have been designed by residents, staff, and families. The facility was preparing to celebrate the upcoming event but at time of audit this was being impacted by covid. There is a varied programme for each area displayed on the walls and rest home and hospital residents receive an individual copy of the programme. In the 'Court' (the dementia unit) the daily activities are dependent on the residents needs on the day and the</p> |

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|  |    | <p>programme is used as a guide. The recreation person and HCAs work together as a team to provide small group and one-on-one activities including reminiscing, walks (unit and garden walks), board games, baking, exercises, ball games, music therapy and sing-a-longs. Residents are encouraged to participate in meaningful activities such as baking and collecting the mail.</p> <p>The service has two vans with wheelchair access for outings into the community, including community exhibitions and scenic drives. Community visitors include churches, volunteers, students, and school children. Each resident has an Oranga Kaumatua (Wellness Map) in their resident file. The activity plan is based on companionship, usefulness, emotion, well-being, and communication and is evaluated at the same time as the care plan. The residents have an opportunity to feedback on the programme through quarterly resident meetings and surveys. Attendance is captured on the electronic resident file and recreation staff record progress notes on the system. Residents and families interviewed reported satisfaction with the activities programme.</p> |
| <p>Standard 1.3.8: Evaluation<br/>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>  | FA | <p>Initial care plans for permanent residents had been evaluated by a RN within three weeks of admission. Long-term care plans have been reviewed at least six-monthly or earlier for any health changes. Evaluations document progress against the resident goals and, as appropriate, cause changes to the long-term care plan. Reassessments have been completed using interRAI for residents who have had a significant change in health status. Short-term care plans reviewed evidenced they had been evaluated and either resolved or added to the long-term care plan if the problem is ongoing. The resident/relatives are involved in the care plan evaluations. The GP/NP reviews the resident at least three-monthly. Ongoing nursing evaluations occur daily/as indicated and are documented within the progress notes. There are six monthly multi-disciplinary reviews.</p>   |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)<br/>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | FA | <p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to the need's assessment coordination service, psychogeriatrician, physiotherapist, wound care specialist, speech language therapist, older persons mental health services and neurologist. There was evidence of re-assessment of levels of care for example from dementia level of care to hospital level of care.</p>  |

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| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | <p>FA</p>              | <p>There are policies and procedures for the disposal of waste and hazardous material. There is an accident/incident system (electronic) for investigating, recording, and reporting all incidents. Chemical supplies are kept in locked cupboards in service areas (kitchen, laundry, and sluice rooms). The contracted supplier provides the chemicals, safety data sheets, wall product charts and chemical safety training as required. Approved containers are used for the safe disposal of sharps. Personal protective equipment is readily available to staff and staff were observed to wearing these as they carried out their duties.</p>  |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>   | <p>PA<br/>Moderate</p> | <p>The building holds a current building warrant of fitness, which expires 22 June 2022. The resident rooms and communal areas are on the ground floor. The upstairs part of the building are staff only areas. The rest home, dual-purpose beds and hospital beds are divided into wings named after the streets of the Monopoly game. The contracted maintenance person spends two days a week on-site and is available as required or after hours for any facility emergencies. Preferred contractors are available 24/7. Staff log any maintenance and repairs into a maintenance system. Planned maintenance is directed from head office and outcomes reported to the property manager. There had been refurbishment to some areas in the home but five bathrooms in the Court (dementia unit) required attention. Electrical testing and tagging had been undertaken July 2021.</p> <p>Clinical equipment has been calibrated annually, last in July 2021. Hot water temperatures are monitored monthly. Records sighted identified corrective action had not been undertaken for hot water temperatures over 45 degrees Celsius or for temperatures lower than residents found comfortable. Fridge temperatures are recorded however there was no evidence that those of the fridges in the three kitchenettes had been taken or recorded. The corridors are wide in all areas to allow safe resident mobility with the use of aids. There are handrails in all corridors which promote safe mobility. There is safe access to external areas for all residents including those in wheelchairs. There is outdoor furniture, seating, and shaded areas. The dementia unit is secure with free access to the external courtyard. The staff interviewed stated that they have all the equipment referred to in care plans to provide care such as platform and chair scales, hoists (lifting and standing and ceiling in some rooms), wheelchairs and shower chairs.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing</p>  | <p>FA</p>              | <p>In the rest home and hospital area, forty-four rooms have an ensuite or shared ensuite. There are communal showers/toilets in all other areas. There are adequate communal showers/toilets, and they are conveniently located close to service areas. One shower room is large enough to accommodate a shower trolley if needed. All showers//toilets have appropriate handrails. There are vacant/occupied signs, privacy</p>   |

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| <p>facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>   |           | <p>locks and shower curtains.</p>  |
| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>  | <p>FA</p> | <p>All resident rooms are single. Dual-purpose rooms are of an adequate size for rest home/hospital level of care. The bedrooms allow the residents to move about independently with the use of mobility aids. The dual-purpose bedrooms are spacious enough to manoeuvre hoists and hospital level lounge chairs. The bedrooms have wide enough doors for ambulance access. Residents and their families are encouraged to personalise the bedrooms as sighted. Residents interviewed confirmed their bedrooms are spacious and they can personalise them as they wish.</p>   |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p> | <p>FA</p> | <p>The rest home has a large dining room and a separate lounge that opens out onto the courtyard. There is a smaller lounge where quieter activities can take place. The open plan dining and lounge area in the hospital opens out onto a courtyard.</p> <p>Seating is placed appropriately to allow for groups and individuals to relax or take part in activities. There are smaller lounges/sunrooms for family visits or quieter activities. There is a large activity room used for large group activities and entertainment for all residents including the day support clients. The facility has a hair salon and chapel. Residents were observed safely moving between the communal areas with the use of their mobility aids. There is adequate space within the hospital communal areas for the easy manoeuvre of specialised lounge chairs.</p>  |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>                     | <p>FA</p> | <p>All linen and personal clothing is laundered on-site. There are two designated laundry staff on duty seven days a week. There is a defined clean and dirty area of the laundry and an entry and exit door. The laundry is well equipped and has a drying room. The machinery is regularly serviced. Adequate linen supplies were sighted in the areas. There is a labeller in the laundry for resident clothing. There are three cleaners (support workers) on duty each day for the facility. The cleaners' cupboard containing chemicals is locked.</p> <p>Cleaning trolleys are well equipped and stored in locked areas when not in use. There is no decanting of chemicals. Laundry and cleaning staff are observed to be wearing appropriate personal protective equipment. Service workers have completed chemical safety. The chemical provider conducts monthly audits on the effectiveness of chemicals and laundry/cleaning processes. The residents interviewed, are satisfied with the cleanliness of the communal areas and their bedrooms.</p> |

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| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>   | <p>FA</p> | <p>There is an emergency management business management plan in place, to ensure health, civil defence and other emergencies are included. Staff interviewed were able to describe the emergency management plan and how to implement this. Emergencies, first aid and CPR are included in the mandatory in-service programme. At least one staff member is on duty at all times with current first aid training. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Six-monthly fire evacuation practice had been interrupted by covid lockdown and was being addressed. A contracted service provides checking of all facility equipment including fire equipment.</p> <p>Smoke alarms, sprinkler system and exit signs are in place. The service has alternative gas facilities (three BBQs) for cooking, in the event of a power failure. There is a battery backup system in place for emergency lighting. Civil defence supplies are available and are checked six-monthly. Emergency food supplies sufficient for three days, are kept in the kitchen. Extra blankets, torches and batteries are available. There is sufficient water stored (water tank of 25,000 litres and bottled water). There are two generators available. There are call bells in the residents' rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</p> |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>                      | <p>FA</p> | <p>All resident rooms and communal rooms have external windows allowing adequate natural light. Windows can be opened safely to allow adequate ventilation. The facility is heated with radiator heating in the communal areas and resident rooms and kept at a comfortable temperature. Residents and relatives interviewed confirmed the environment and the bedrooms are warm and comfortable.</p>  |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p> | <p>FA</p> | <p>The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the designated infection control coordinator. She was designated in this role in August 2021 and supported by the clinical coordinator. She has completed her infection prevention and control (IPC) online training and has signed a copy of her IPC job description.</p> <p>Infections are monitored and recorded on the patient management system. Benchmarking of infection control data is completed, and actions identified to reduce infection rates if above benchmark in any category. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection prevention and control programme has</p>  |



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|  |    | been reviewed annually.  |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>  | FA | <p>There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The infection control coordinator has good external support from the PSC clinical director and PSC nurse consultants. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p> <p>The IPC team has been re-organised. This is comprised of HCAs, housekeeper, laundry, and kitchen staff to ensure that infection prevention and control is being upheld in all areas of the home.</p> <p>Covid-19 – There were resources available including written materials, pamphlets, polices and Covid-19 prevention and management plan. There were number of covid-19 emergency containers full of PPE, hand sanitizer, notices, gloves etc. There are 'ready to go' kits made up ready to be used for suspected cases.</p> |
| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> | FA | <p>PSC has a comprehensive policy in place to guide IPC practice. The policies have been reviewed and updated. PSC has Clinical Director and Clinical Nurse Consultants, one with an IPC Portfolio supports the infection control coordinator at Woburn.</p> <p>Infection control audits are undertaken to ensure compliance with policies and procedures. .</p>   |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>  | FA | <p>Formal infection control education for staff has occurred along with education at staff handovers. The infection control coordinator has undertaken the PSC infection control day training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p> <p>The infection control coordinator is responsible for coordinating/providing education and training to staff.</p>  |

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|   |    | Due to covid 19 pandemic increased number of infection control training is provided. This is mainly around hand hygiene, standard precautions and use of masks, and covid 19 screening. Woburn maintains emergency stock for infections outbreak including masks, antibacterial gels, and protective clothing.   |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>   | FA | <p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs at Woburn Home. Internal infection control audits also assist the service in evaluating infection control needs. A monthly collation of infections, trends and analysis including microbiology results is completed on the digital platform. Corrective actions for events above the benchmarking key performance indicators (KPIs) is reported to the senior team and clinical/RN meetings.</p> <p>Woburn Home had an outbreak of gastroenteritis in June 2021. Infection control policies and procedures and advice from the Public Health Authority were followed during this outbreak.</p>   |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>  | FA | <p>The service has policies and procedures to support of the use of enablers and restraints. The policy meets the intent of the restraint minimisation standards. The clinical nurse manager is the restraint coordinator. There was one resident with restraint (lap belt when in wheelchair) and two residents with enablers (bedrails) on the day of audit. Consents (voluntary for enablers) and assessments for residents with enablers were up to date. Documented enabler monitoring is in the progress notes each shift. The enablers are reviewed three-monthly as part of the GP/NP three monthly review. Risks associated with the use of enablers have been identified in the assessment. The files reviewed of residents with enablers, had identified risks/interventions clearly documented within the resident care plan. Restraint minimisation, enabler training and challenging behaviour is included in the education planner.</p> |
| <p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and</p> | FA | <p>The role and responsibility for the restraint coordinator is included in the restraint policy. Registered nurses complete a restraint self-learning package on orientation and ongoing education is included in the education planner. Care staff receive training on minimisation of, and safe use of restraint. The restraint minimisation and enabler policy clearly describe responsibilities for staff.</p>  |

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| <p>this process is made known to service providers and others.</p>   |    |  |
| <p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p> | FA | <p>The restraint coordinator undertakes restraint assessments in consultation with the RNs, GP/NP and in partnership with the family/whānau. Restraint assessments are based on information in the care plan, resident discussions and on observations by the staff. There is a restraint assessment tool available, which is completed for residents requiring an approved restraint for safety. Assessments for the resident on restraint were reviewed and were completed as required and to the level of detail required for the individual resident. Completed assessments considered those factors listed in 2.2.2.1 (a) - (h).</p>  |
| <p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>   | FA | <p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. Monitoring and observation are included in the restraint policy. There are approved restraints documented in the policy. The restraint coordinator is responsible for ensuring all restraint documentation is completed. The approval process includes ensuring the environment is appropriate and safe. Restraint authorisation is in consultation/partnership with the resident (as appropriate) or whānau/EPOA, GP/NP, the PSC nurse consultant, and the facility restraint coordinator (CNM). Monitoring is documented(electronically) as instructed and sighted in the restraint files reviewed.</p> |
| <p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>  | FA | <p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur three-monthly as part of the ongoing reassessment for the resident on the restraint register, and as part of the care plan and GP/NP review.</p>   |
| <p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>          | FA | <p>Restraint use in the facility is evaluated in the monthly senior team meeting and two-monthly by the PSC restraint meeting. The restraint coordinators from each facility exchange care plans of residents restrained for evaluation by their colleagues prior to the meeting where they are discussed. Policies are reviewed by this group of clinical nurse managers and the PSC nurse consultant. Internal restraint audits identify any areas for improvement.</p>  |

## Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

| Criterion with desired outcome  | Attainment Rating | Audit Evidence  | Audit Finding  | Corrective action required and timeframe for completion (days)         |
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| <p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p> | PA Low            | <p>Presbyterian Support Central has an overall quality monitoring programme (QMP) that is part of the quality programme and includes internal benchmarking with the other PSC sites. Internal audit programme is implemented, and benchmarking results were used for quality improvement activities. Corrective actions were identified following audits and incident accidents reporting and follow ups and sign off were completed by the interim manager. There is an annual and monthly meeting calendar and agenda to ensure consistent communication not only internally in Woburn but throughout the organisation. Meetings were not however, undertaken as scheduled.</p> | <p>Resident meetings are scheduled three monthly and family meetings are scheduled six-monthly. However there has only been two meetings held in 2021 YTD (Residents in September and Families in March). Clinical meetings and staff meetings are scheduled monthly; but have been held irregularly. There were no meetings in February, March, and April 2021. There were no separate health and safety meetings as scheduled, however health and safety</p> | <p>Ensure that the meeting schedule is implemented</p> <p>180 days</p> |

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|  |        |  | issues are discussed at the staff meetings. There are twice weekly scheduled senior team 'huddle' meetings, but these have been held irregularly.                      |   |
| <p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p> | PA Low | Health and safety meetings are scheduled three-monthly; however, have not been completed as scheduled. Health and safety issues are discussed at the staff meetings. The hazard register was reviewed in September 2021. A number of staff resigned in the last six months, and these included health and safety representatives. A new health and safety representative has been appointed as a health and safety officer; however, has not yet completed health and safety training. | The health and safety officer has not completed health and safety representative training and there are no other staff with health and safety representative training. | <p>Ensure that health and safety representation training is completed by the health and safety officer.</p> <p>180 days</p> |
| <p>Criterion 1.2.7.4</p> <p>New service providers receive an</p>   | PA Low | Woburn Home completed an internal audit around compliance of human resource management practices. This identified that number of staff orientation records were either missing or not completed. A corrective action plan  | Twelve personnel files were reviewed, two were new staff members who had not completed their orientation   | Ensure that staff orientation is completed,   |

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| <p>orientation/induction programme that covers the essential components of the service provided.</p>   |               | <p>was put in place in August 2021, and this is still work in progress.</p>   | <p>and they were not due. Two of the 10 remaining files did not have completed orientation record.</p>   | <p>and completion records are maintained.</p> <p>180 days</p>   |
| <p>Criterion 1.2.7.5<br/>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p> | <p>PA Low</p> | <p>PSC Enliven has in place a comprehensive three-year compulsory training programme for RNs and HCAs to ensure all training requirements are being met. The structure includes a booking system for the RN component and training resources. The two Enliven trainers are supported by a part time training administrator. This enables the Enliven trainers to focus on programme development as well as providing training. Training programme in 2020 and 2021 were not fully implemented including compulsory training such as Treaty of Waitangi and manual handling. Education framework audit shows 44% compliance in August 2021. Following this internal audit, two training days were provided to staff in August 2021 and September 2021. Eighteen staff in total received training that included all compulsory topics such as consumer rights, aging process, communication, behaviour management palliative care, sexuality, cultural competency, Treaty of Waitangi, and Eden Alternative. On the other hand, a number of infection control trainings, particularly around Covid-19, have been provided to staff; the latest training records shows 37 staff have completed this training.</p> <p>There are 11 staff members and plus bureau staff who work in the dementia unit. Three of 11 Woburn staff have not completed the required dementia specific training. Two of the three staff members have been working in the unit for the last two years.</p> <p>Performance appraisals are scheduled yearly but not all were completed as planned. Management advised that</p> | <p>Annual mandatory training has not been completed in 2020 and 2021. (ii) Three out of 11 staff members in the dementia unit have not completed the required dementia specific unit standards. (iii) Performance appraisals were not all undertaken in the last two years. Four of 11 staff files did not have an annual performance appraisal. Four staff members who had current 2021 appraisals also did not have one in 2020.</p> | <p>(i) Ensure that annual training plan is implemented. (ii) Ensure that staff who work in the dementia unit have undertaken dementia specific unit standards. (iii) Ensure that staff performance appraisals are completed annually.</p> <p>180 days</p> |

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|   |                        | PSC currently has 10% of their nurses with a current PDRP. Woburn has one nurse who has completed her PDRP, she is at competent level.  |  |   |
| <p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>  | <p>PA<br/>Moderate</p> | <p>Hot water monitoring identified that there were inconsistencies in water temperature – both too high and at times too low.</p> <p>Temperatures of the kitchen fridge, freezer and cool store were taken and recorded, but there were also fridges in the three kitchenettes adjacent to lounges which were not evidenced as being monitored.</p> | <p>i). Inconsistencies with hot water temperatures had been identified in 2020 and a corrective action plan written for action in November 2021.</p> <p>ii). There was no evidence of the taking or recording of the temperatures of the kitchenette fridges which contained milk and some food for residents.</p> | <p>i). Ensure corrective actions around hot water temperatures occur in a timely manner.</p> <p>ii). Ensure temperatures of the fridges in the kitchenettes are recorded at least daily.</p> <p>30 days</p> |
| <p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p> | <p>PA Low</p>          | <p>Some areas of the home had been refurbished since the previous audit and refurbishments were continuing. On the days of audit, the rest home dining room was being refloored.</p>  | <p>In the Court (dementia unit) there were five bathrooms with cracked vinyl coverings. This is an infection and falls risk.</p>   | <p>To repair/replace surfaces that may be an infection risk or a falls risk.</p> <p>90 days</p>   |

## Specific results for criterion where a continuous improvement has been recorded

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As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.